Maryland Department of Health
Office for Genetics and Children with Special Health Care Needs
Children's Medical Services (CMS)

Request for Pre-Authorization of Services

Instructions for Completion of Form 4510

NOTE: *All providers must initiate and complete Form 4510. CMS regulations, Children's Medical Services Program (COMAR 10.11.03), mandate that the Providers of service request authorization on forms designated by CMS. The Provider must initiate this process via Form 4510 when service to a CMS eligible patient is anticipated. By* ***FAXING or EMAILING*** *the completed form to CMS as directed on Form 4510.*

Provider#
Enter the Provider's Medical Assistance Provider Number which will be used for billing for the type of service to be provided.

Provider/Facility
Insert the name of the Provider/Facility and Clinic which the service will be billed.

Phone and Fax
Enter the appropriate numbers to the areas where the service will be provided.

Child's SSN/CMS#
Insert the patient's nine (9) digit Social Security Number or CMS ID Number.

County or Baltimore City
Enter the patient's county of residence or "CITY" for Baltimore City residents.

Health Insurance
If applicable, enter the patient's private insurance company's Name and policy number.

Diagnosis
Enter the patient's diagnosis or description of problem which relates to this request.

Service(s) Requested
Check the appropriate block. Add a comment to specify "Other".

Lines 1-5
Begin, End – Enter a specific date under "Begin" and "End" if possible or indicate range of dates within which you anticipate providing the service.

CPT Code – Enter the five (5) digit Medicaid billing CPT or HCPCS code for all services excluding hospital facility services.

Procedure – Enter a description of the procedure, item or service.

Number of Services – For non-hospital services, enter the number of services.

Estimated Charge – Enter an estimate of the charge for the service.

Signature, Title and Telephone
Enter the person who will respond to questions from CMS staff about the request. Date the request.

Send Authorization to:
Enter the person and/or office address to which the CMS written authorization should be sent.

Telephone/ FAX
Enter the numbers of the office which should receive the written CMS authorization.

***<u>**Reminders**</u>**: Providers can and should follow up with CMS within 48 hours after you submitted a 4510 Form Request.
The service must be requested within a minimum of two weeks notices, before the service is rendered. CMS does not process retro-active requests and CMS will only cover those services that had been approved/pre-authorized.

Maryland Department of Health

Larry Hogan, Governor – Boyd Rutherford, Lt. Governor – Dennis R. Schrader, Secretary
Office for Genetics and People with Special Health Care Needs
Children's Medical Services Program

Request for Pre-Authorization of Services

Return to:

CMS Program - Phone: 410-767-5588/1-800-638/8864 - e-Fax: 443-275-5434 (Primary) - Fax: 410-333-7956 (secondary)
Email: mdh.childrensmedicalservices@maryland.gov

Referral to:

MA Provider #: ___ ___ ___ ___ ___ ___ ___ ___ ___

Provider's Name:_____ Facility/Clinic: _____

Phone:_____ Fax: _____

Child's Name:_____ Birth Date: _____
Last ***First*** ***MI***

Child's SSN/**CMS#**:_____ - ____ - _____ MA#:__ __ __ __ __ __ __ __ __ __ __

County or Baltimore City:_____ Phone: _____

Health Insurance: _____
Name and Policy Number

Diagnosis:_____

Reason for Referral: _____ Clinical Notes Attached:___Y ___N

Service(s) Requested: ____ In-Patient ____ Clinic _____ Dental ____ Other: _____

Dates:

	Begin	End	CPT Code	Procedure or Service	Number Of Services	Estimated Charge
1.	___/___/___	___/___/___	_____	_____	_____	_____
2.	___/___/___	___/___/___	_____	_____	_____	_____
3.	___/___/___	___/___/___	_____	_____	_____	_____

_____ _____ ___/___/___
Signature of Individual Completing Form **Telephone** **Date of Request**

Email of Individual Completing Form (optional):_____

_____ _____
Title/Agency

Send Authorization to:

_____
Name/Agency

_____
Street

_____ _____
City *Zip Code*

_____ _____
Telephone *Fax*

For Office Use Only

Service Type _____ CA Item _____
Approved Initial _____ Date_____
On Line Save Initial _____ Date_____
Bill Approved Initial _____Date_____

Authorization #: _____

Comment _____

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